1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03881

3882

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-58 10M

1. PLACE OF DEATH

COUNTY: CARROLL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNIONTOWN
MARYLAND
LENGTH OF STAY (In this place): YEARS
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: MARYLAND
COUNTY: CARROLL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNIONTOWN
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) DAVID (Last) ALBAUGH

4. DATE OF DEATH (Month) APRIL (Day) 11 (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED	2/6/1876	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MACHINIST-FARMER-RETIRED		MARYLAND	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
THOMAS A. ALBAUGH	ELIZA BROWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
NO	NO	218-14-4840	MAUDE ALBAUGH, UNIONTOWN MD

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-10, 1957, to 4-11-, 1957, that I last saw the deceased alive on 4-11-, 1957, and that death occurred at 4:?? M, from the causes and on the date stated above.

SIGNATURE J. H Legg M.D. **ADDRESS** (Street, city, town, state) Union Bridge Md **DATE SIGNED** 4-12-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	4/14/57	PIPE CREEK CEM	CARROLL COUNTY MD

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
APR 15 1957	T. T. Fedrick	D.O. Hartsfeld Sons	Union Bridge Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3883

CERTIFICATE OF DEATH

03882

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 mos, 17 dys
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 418 Potomac Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eleanora; Middle: ; Last: ALBERT

4. DATE OF DEATH: Month: April; Day: 9; Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 15, 1862

9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Albert

14. MOTHER'S MAIDEN NAME: Mary Katherine Mumma

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: - None

17. INFORMANT: Springfield Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia unresolved — INTERVAL BETWEEN ONSET AND DEATH: 2 days

491X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome assoc. with cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 22, 1957, to April 9, 1957, that I last saw the deceased alive on April 9, 1957, and that death occurred at 6:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 4/9/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/11/1957
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
R. Franklin Rouzer
ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: 4-15-57
24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar or coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3884 CERTIFICATE OF DEATH

Reg. Dist. No. 03883 96

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Westminster
c. LENGTH OF STAY IN 1b: 16 months x2

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R. 4

d. STREET ADDRESS: 1 Springdale Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Hazel Last: Baldwin

4. DATE OF DEATH: Month: April Day: 23 Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 13, 1884

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Isaac H. Baldwin

14. MOTHER'S MAIDEN NAME: Jane A. Newhouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: - - - - - -

17. INFORMANT: Lelia G. Baldwin Address: Taneytown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

443X

DUE TO (b): Hypertension — years (?)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ? 19 33, to 4-25- 19 57, that I last saw the deceased alive on 4-22- 19 57, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. C. Stone M.D. ADDRESS (Street, city or town, state): 121 E Green St DATE SIGNED: 4/23/57

PHYSICIAN'S NAME (Type): W. C. Stone, M.D. 121 E. Green St. Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 4-23-57

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John R. Byers ADDRESS: Westminster, Maryland

24a. REC'D BY REGISTRAR DATE: 4-24-57

24b. REGISTRAR'S SIGNATURE: Howard Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03884

3885

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr. 8mos. 21days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 V o l - 4
d. STREET ADDRESS: 2235 Kentucky Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

3. NAME OF DECEASED (Type or print): First: Benjamin — Middle: Edward — Last: BELL

4. DATE OF DEATH: Month: April — Day: 24 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 18, 1859

9. AGE (In years last birthday): 97 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Unk

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Bell

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2-3 days

491X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/3/55, 19__ to 4/24/57, 19__, that I last saw the deceased alive on 4/24/57, 19__, and that death occurred at 8:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 4/24/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: April 27, 1957
22c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HENRY SANDER & SONS, INC. Balto., Md.

24a. REC'D BY REGISTRAR DATE: 4-24-57
24b. REGISTRAR'S SIGNATURE: C. Harry Heer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 ★

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

~~3886~~ 03885

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Items 8,9; 6214 4/24/57

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton, Maryland
c. LENGTH OF STAY IN 1b: 56 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 0210.2 ✓
d. STREET ADDRESS: 79 W. Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Westley — Last: Belt

4. DATE OF DEATH: Month: April — Day: 15 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: March 8, ~~1906~~ 1906

9. AGE (In years last birthday): 51 53 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Belt

14. MOTHER'S MAIDEN NAME: Nannie Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: George Walter Belt - 118 O'Berry Ct.-Annapolis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Far advanced bilateral cavitary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH

0027

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 18, 1957, to April 15, 1957, that I last saw the deceased alive on April 15, 1957, and that death occurred at 12:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: T. F. Vestal, M.D. — ADDRESS (Street, city or town, state): Henryton, Maryland — DATE SIGNED: 4-15-57

PHYSICIAN'S NAME (Type): T. F. Vestal, Superintendent — Henryton State Hospital, Henryton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-18-57

22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese Jr. — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 4-15-57

24b. REGISTRAR'S SIGNATURE: Albert R. Swanborn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03886

CERTIFICATE OF DEATH

3887

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 14 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 21
d. STREET ADDRESS: 2802 Herkimer Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel — Middle: — Last: Bene

4. DATE OF DEATH: Month: April — Day: 2 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-3-11

9. AGE (In years last birthday): 46 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Comptometer Operator

10b. KIND OF BUSINESS OR INDUSTRY: Telephone Company

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Bene

14. MOTHER'S MAIDEN NAME: Ethel Tiyekker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ---------

17. INFORMANT: Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Liposarcoma of the breast tissue, — INTERVAL BETWEEN ONSET AND DEATH: 1 year

170 x

DUE TO: with metastasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) — DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia, paranoid type

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-8- 1942, to 4-2- 1957, that I last saw the deceased alive on 4-2 1957, and that death occurred at 11:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Bertrud Sonnenfeld M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital Sykesville Md. — DATE SIGNED: 4/27/57

PHYSICIAN'S NAME (Type): Bertrud Sonnenfeld M.D. Springfield State Hospital Sykesville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem

22d. LOCATION (City, town, or county) (State): Frederick Rd Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Foulson — ADDRESS: 2359 West Pratt St Baltimore Md

24a. REC'D BY REGISTRAR: DATE: 3 1957

24b. REGISTRAR'S SIGNATURE: C. Harry Fearn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be re-filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3888

03887

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine
c. LENGTH OF STAY IN 1b (Years) (Months) about 10 yrs

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Md b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R1 Woodbine
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
e. STREET ADDRESS Washington Blvd Eden Mill Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First JOSHUA Middle LEVERING Last BOWEN
4. DATE OF DEATH Month April Day 3 Year 1957
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug 6, 1895
9. AGE (In years last birthday) 61 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Owner
11. BIRTHPLACE (State or foreign country) Randallstown Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME John W. Bowen
14. MOTHER'S MAIDEN NAME Annie E. Herbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 217-36-4235
17. INFORMANT Mildred C. Bowen Address Washington Blvd & Eden Mill Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, Cardiac — INTERVAL BETWEEN ONSET AND DEATH 1945
DUE TO (b) failure, Arteriosclerosis, Obesity. — TO April 1957
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MARCH, 1957, to April, 1957, that I last saw the deceased alive on 3 April, 1957, and that death occurred at 3:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Howard E. Hall M.D. ADDRESS (Street, city or town, state) Sykesville, Md DATE SIGNED 3 April 57

PHYSICIAN'S NAME (Type) Howard E. Hall

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 4/6/1957
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge
22d. LOCATION (City, town, or county) (State) Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE Leroy Myers ADDRESS 8728 Liberty Road Randallstown Md.
24a. REC'D BY REGISTRAR DATE 4/3/57
24b. REGISTRAR'S SIGNATURE Edna Hewitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03888

3889 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d STREET ADDRESS: 633 N. Fremont Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: — Last: Brown

4. DATE OF DEATH: Month: 4 — Day: 22 — Year: 19 57

5 SEX: Male
6 COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 16, 1907
9 AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Odd Jobs
10b. KIND OF BUSINESS OR INDUSTRY: Interior Decorator
11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lonzo Brown
14 MOTHER'S MAIDEN NAME: Catherine ???

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: William Brown - Patient — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Far advanced bilateral cavitary pulmonary TB. — INTERVAL BETWEEN ONSET AND DEATH

002A

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 10, 19 57, to April 22, 19 57, that I last saw the deceased alive on April 22, 1957, and that death occurred at 10:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: T. F. Vestal M.D. — ADDRESS (Street, city or town, state): Henryton State Hospital, Henryton, Md. — DATE SIGNED: 4/22/57

PHYSICIAN'S NAME (Type): T. F. Vestal, Superintendent — Henryton State Hospital, Henryton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-25-57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
22d. LOCATION (City, town, or county) (State): Balto. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Miss Karen K. McKinnon — ADDRESS:

24a. REC'D BY REGISTRAR DATE: 4-23-57
24b. REGISTRAR'S SIGNATURE: Albert R. Swinkham

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3890 **CERTIFICATE OF DEATH** 03889

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylorsville
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Md b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylorsville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Elsie Middle: Pearl Last: Browning

4. DATE OF DEATH Month: April Day: 5 Year: 1957

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 10-6-1884

9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wm T. Newsom

14. MOTHER'S MAIDEN NAME Martha E Stone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Address: Mrs Betty Hess - Taylorsville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest, Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1954
DUE TO (b) Ventricular Fibrillation, Congestive failure, — 1957
DUE TO (c) Hypertension,

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4.2.0.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1952, 19__, to April, 1957 that I last saw the deceased alive on 5 April, 1957, and that death occurred at 12:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Howard E Hall M.D. ADDRESS (Street, city or town, state) Taylorsville, Md DATE SIGNED 4-6-57

PHYSICIAN'S NAME (Type) HOWARD E. HALL

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 4-8-57

22c. NAME OF CEMETERY OR CREMATORY Mt Union

22d. LOCATION (City, town, or county) Hampstead (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Luther F Haight ADDRESS Taylorsville Md

24a. REC'D BY REGISTRAR DATE 4-6-57

24b. REGISTRAR'S SIGNATURE C Harry Weaver

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3891 **CERTIFICATE OF DEATH**

03890 Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 13,
d. STREET ADDRESS: 3220 Belair Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Plumber Last: Burgee

4. DATE OF DEATH: Month: 4 Day: 19 Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-26-73

9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): machinist

10b. KIND OF BUSINESS OR INDUSTRY: Mach

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Burgee

14. MOTHER'S MAIDEN NAME: Esther Temple

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unkn
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unkn

17. INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thrombosis of sigmoid sinus — INTERVAL BETWEEN ONSET AND DEATH: days
241X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr. brain syndr. assoc. with cerebral arterioscler. with psych. reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-5- 19 57, to 4-18- 19 57, that I last saw the deceased alive on 4-18- 19 57, and that death occurred at 6:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund B. Lusthaus M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 4-19-57

PHYSICIAN'S NAME (Type): Edmund B. Lusthaus M.D. Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-22-57
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
22d. LOCATION (City, town, or county) (State): Woodlawn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William Cook, Inc., 1217 St. Paul Street

24a. REC'D BY REGISTRAR DATE: 4-19-57

24b. REGISTRAR'S SIGNATURE: C. Henry Uhler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filmed 4-12-57 et 3892

CERTIFICATE OF DEATH

03891

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A-5 (4) 15M 7/55

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne, Maryland
d. STREET ADDRESS: Rt. 1, Box 115, Mt. Vernon
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: Burke

4. DATE OF DEATH: Month: April — Day: 7 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-2-1891

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eddie Burke

14. MOTHER'S MAIDEN NAME: Sarah (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-09-1444

17. INFORMANT: Address: Russell Burke-Rt. 2, Box 26 Eden, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Edema Pulmonum
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Heart Failure
DUE TO
(c): Pulmonary Tuberculosis-Far Advanced

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. p. m. / Month / Day / Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 28, 1957, to April 6, 1957, that I last saw the deceased alive on April 6, 1957, and that death occurred at 12:10 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: I. E. Vestal M.D.
ADDRESS (Street, city or town, state): Henryton, Maryland
DATE SIGNED

PHYSICIAN'S NAME (Type): Henryton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/6/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Vernon Cemetery
22d. LOCATION (City, town, or county) (State): Mt. Vernon, Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Stewart Funeral Home, Salisbury, Md
ADDRESS

24a. REC'D BY REGISTRAR
DATE

24b. REGISTRAR'S SIGNATURE: Albert R. Lowe

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03892

Item 2 Film C214 4-29-57 S+

3893

CERTIFICATE OF DEATH

Reg. Dist. No. 774

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Maryland
c. LENGTH OF STAY IN 1b: 7yrs. 2mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 4324 Belvieu Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Virginia; Middle: Pearl; Last: Clifford

4. DATE OF DEATH: Month: 4; Day: 12; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-26-1884

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Music teacher

10b. KIND OF BUSINESS OR INDUSTRY: Hosp

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Keene Clifford

14. MOTHER'S MAIDEN NAME: Mary Virginia Dobson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: Unk

17. INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: ½ hr.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis — 10 yrs.
DUE TO
(c): Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 5-11-50, 19__, to 4-12-, 1957, that I last saw the deceased alive on 4-12-, 1957, and that death occurred at 3:45 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: M. N. Mastin, M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 4-12-57

PHYSICIAN'S NAME (Type): M. N. Mastin, M.D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-16-57
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther A. Haight
ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: 4-16-57
24b. REGISTRAR'S SIGNATURE: C. Harry West

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03893

CERTIFICATE OF DEATH

3894

Reg. Dist. No. 174

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Oakland Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
d. STREET ADDRESS: Oakland Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Melissa — Middle: Ann — Last: Conaway

4. DATE OF DEATH: Month: April — Day: 8 — Year: 19 57

5. SEX: F.

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 18 1884

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Phillips

14. MOTHER'S MAIDEN NAME: Adeline Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-12-2405

17. INFORMANT: Mrs Retta McDaniel — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Paralysis Agitans — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. / p. m. 19

20d. INJURY OCCURRED: White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1950, 19___, to 8 April, 19 57, that I last saw the deceased alive on 8 April 1957, and that death occurred at 5:50 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm H Lawson M.D. — ADDRESS (Street, city or town, state): Liberty Road at Eldersburg — DATE SIGNED: 4.8.57

PHYSICIAN'S NAME (Type): Wm. H. Lawson, Jr., M.D. — Sykesville P.O., Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-11-57

22c. NAME OF CEMETERY OR CREMATORY: Mt Pleasant

22d. LOCATION (City, town, or county) (State): Hoober, Carroll, Md.

23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: Luther A Haight - Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: 4-9-57

24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3895

CERTIFICATE OF DEATH

03894

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Westminster
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Rural--Sykesville
d. STREET ADDRESS: R.D. 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle MARSHALL Last COOK

4. DATE OF DEATH: Month APRIL Day 15, Year 1957

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 3,1887

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: general

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Cook

14. MOTHER'S MAIDEN NAME: Phoebe Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 229-12-7168

17 INFORMANT Address: Mrs. Evelyn Gibson, Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broncho-Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Influenza a — 10 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Chronic Myocarditis — 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 422.2

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/10, 19 57, to 4/15, 19 57, that I last saw the deceased alive on 4/15, 19 57, and that death occurred at 11 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Luther Bare M.D. ADDRESS (Street, city or town, state): Westminster, Maryland DATE SIGNED: 4/16/57

PHYSICIAN'S NAME (Type): S. LUTHER BARE

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4-19-1957

22c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery

22d. LOCATION (City, town, or county) (State): Carroll CO., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz, Winfield, Maryland

24c. REC'D BY REGISTRAR DATE: APR 22 1957

24b REGISTRAR'S SIGNATURE: Augusta Butler May Farrell D

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03895

3896 **CERTIFICATE OF DEATH**

Reg. Dist. No. 26

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural WESTMINSTER
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) R.D. 3

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE MD. b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural WESTMINSTER
d. STREET ADDRESS RD 3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First JOSEPH Middle Last COTINGAME
4. DATE OF DEATH Month 4 Day 11 Year 1957
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH APRIL 15-1878
9. AGE (In years last birthday) 78 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) KY.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME R.W. COTINGAME
14. MOTHER'S MAIDEN NAME SYNTHIA SIZEMORE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT JOHN COTINGAME Address R.D. 3 WESTMINSTER MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 6 hrs
DUE TO (b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 11, 1957, to April 11, 1957, that I last saw the deceased alive on April 11, 1957, and that death occurred at 5 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE W H Foard M.D. ADDRESS (Street, city or town, state) Manchester, Md. DATE SIGNED 4/12/57

PHYSICIAN'S NAME (Type) W. H. Foard.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 4-15-1957
22c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEM.
22d. LOCATION (City, town, or county) (State) WESTMINSTER MD

23. FUNERAL DIRECTOR'S SIGNATURE Edward C. Bankard ADDRESS Westminster, Md.
24a. REC'D BY REGISTRAR DATE 4-16-57
24b. REGISTRAR'S SIGNATURE Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3897 CERTIFICATE OF DEATH

Reg. Dist. No. 03896

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RURAL

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: MARYLAND b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
d STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First OLIVE Middle MARGARET Last CRUSHONG

4. DATE OF DEATH: Month APRIL Day 26 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 24-1887

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM T METZ

14. MOTHER'S MAIDEN NAME: ANNIE B KEENEY

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-14-4594

17. INFORMANT: ELLIS CRUSHONG Address: RURAL UNION BRIDGE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/16 19 56 to 4/26 19 57 that I last saw the deceased alive on 4/26 19 57, and that death occurred at 8 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: M. E. Robertson M.D. ADDRESS (Street, city or town, state): New Windsor, Md. DATE SIGNED: 4/26/57

PHYSICIAN'S NAME (Type): M. E. Robertson M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 4/29/57
22c. NAME OF CEMETERY OR CREMATORY: REFORMED
22d. LOCATION (City, town, or county) (State): TANEYTOWN MD

23. FUNERAL DIRECTOR'S SIGNATURE: D D Hartzler Sons ADDRESS: Union Bridge Md.

24a. REC'D BY REGISTRAR DATE: APR 30 1957

24b. REGISTRAR'S SIGNATURE: Leslie L. Repp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3898 **CERTIFICATE OF DEATH** Reg. Dist. No. 03897

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 10100 Vaughn Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elwood — Middle Richard — Last Davis
4. DATE OF DEATH: Month 4 — Day 7 — Year 1957

5. SEX: male
6. COLOR OR RACE: negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-26-23
9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Cement Worker
11. BIRTHPLACE (State or foreign country): Charles Co., Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Da vis
14. MOTHER'S MAIDEN NAME: Catherine Everhart(Kelly)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or date of service)
16. SOCIAL SECURITY NO: 578-20-6226
17. INFORMANT: Rosetta Davis — Address: Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bilateral Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH:
102X
DUE TO (b): Pulmonary Tuberculosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-7, 1957, to 4-7, 1957, that I last saw the deceased alive on 4-7, 1957, and that death occurred at 6.10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: T.F. Vestal M.D. — ADDRESS (Street, city or town, state): Henryton, Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): T.F. Vestal — Henryton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-10-57
22c. NAME OF CEMETERY OR CREMATORY: Ash Memorial
22d. LOCATION (City, town, or county) (State): Sandy Spring, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville Md.
24a. REC'D BY REGISTRAR DATE: 4-7-57
24b. REGISTRAR'S SIGNATURE: Albert R. Snowden

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 F[illegible] 5 [illegible]-57

3899

CERTIFICATE OF DEATH

03898

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3 mo 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 14 Marion Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pauline — Middle: Virginia — Last: Davis

4. DATE OF DEATH: Month: 4 — Day: 27 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-27-07

9. AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wesley Lizer

14. MOTHER'S MAIDEN NAME: Blanch Haugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unkn

17. INFORMANT: Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: Bronchopneumonia due to undetermined cause — weeks

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr. brain syndr. assoc. with cerebral arteriosclerosis with psych.react.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-21-57, 19___, to 4-27, 1957, that I last saw the deceased alive on 1-26-, 1957, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund B. Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 4-27-57

PHYSICIAN'S NAME (Type): Edmund B. Lusthaus — Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-30-57

22c. NAME OF CEMETERY OR ~~CREMATORY~~: Hill Crest Memorial

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Ottix, Inc. — ADDRESS: Cumberland, Md

24a. REC'D BY REGISTRAR DATE: 4-28-57

24b. REGISTRAR'S SIGNATURE: C Harry Weed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be [illegible]ched for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3900 CERTIFICATE OF DEATH

03899 74
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: Since 7-21-55
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick
d. STREET ADDRESS: 1200 W. Market Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: Lee — Last: Derry

4. DATE OF DEATH: Month: April — Day: 3 — Year: 19 57

5 SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-12-65

9. AGE (In years last birthday): 91 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant - ret. farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Phillip Derry

14 MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Springfield State Hosp. records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

447X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertension — 15 years

DUE TO (c): Generalized Arteriosclerosis — 15 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS associated with cerebral arteriosclerosis, psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 24, 1956 to April 3, 1957, that I last saw the deceased alive on April 3, 1957, and that death occurred at 12:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Cross M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 4-3-57

PHYSICIAN'S NAME (Type): Martin Cross, M. D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-6-1957
22c. NAME OF CEMETERY OR CREMATORY: Fairview Luth. Cemetery
22d. LOCATION (City, town, or county) (State): Bolivar-West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: W. E. Cline & Son — ADDRESS: Frederick-Md.

24a. REC'D BY REGISTRAR DATE: 5 April 1957

24b. REGISTRAR'S SIGNATURE: C. Barry Myers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3901 — 03900 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNIONTOWN
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNIONTOWN
d STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First J. Middle SNADER Last DEVILBISS

4. DATE OF DEATH: Month APRIL Day 12 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8 DATE OF BIRTH: 1/27/1869

9 AGE (In years last birthday) 88 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER - RETIRED - OWNER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: J. THOMAS DEVILBISS

14. MOTHER'S MAIDEN NAME: MARTHA SNADER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: T. L. DEVILBISS — Address: UNIONTOWN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-6-, 1957, to 4-11-, 1957, that I last saw the deceased alive on 4-11-, 1957, and that death occurred at 5 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. N Legg M.D. — ADDRESS (Street, city or town, state): Union Bridge — DATE SIGNED: 4-12-57

PHYSICIAN'S NAME (Type): T. H LEGG MD — Union Bridge Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 4/14/57 — 22c. NAME OF CEMETERY OR CREMATORY: METHODIST CEM. — 22d. LOCATION (City, town, or county) (State): UNIONTOWN, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: D. D. Hartzler Sons — ADDRESS: New Windsor Md.

24a REC'D BY REGISTRAR DATE: APR 15 1957 — 24b. REGISTRAR'S SIGNATURE: D. F. Fedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3878

CERTIFICATE OF DEATH

03901

Reg. Dist. No. 26

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 172 W. Main St.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 172 W. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Alexander — Last: Early

4. DATE OF DEATH: Month: April — Day: 27 — Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 23, 1883

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Harrisonburg, Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Abraham Early

14. MOTHER'S MAIDEN NAME: Hannah Mary Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-16-0303

17. INFORMANT: Mrs. George A. Early — Address: 172 W. Main St. Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 7 to 9 mo

DUE TO (b): Anemia & Cachexia — 6 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 15"x

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21) I certify that I attended the deceased from Sept. 19 56, to April 27, 19 57, that I last saw the deceased alive on April 27, 19 57, and that death occurred at 3:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Lewis Speicher MD — ADDRESS (Street, city or town, state): Westminster — DATE SIGNED: 4/29/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/30/57

22c. NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery

22d. LOCATION (City, town, or county) (State): Westminster, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: 4-29-57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03902

3879

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 20 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d STREET ADDRESS: 4 S. Caroline Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Tom; Middle: ; Last: Evans

4. DATE OF DEATH: Month: April; Day: 24; Year: 1957

5 SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-4-1902

9 AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sells Seafood

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Georgia

12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Joe Evans

14. MOTHER'S MAIDEN NAME: Emma ??

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Tom Evans - Patient
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Tuberculous lymph adenitis (biopsy)
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Abdominal malignancy diagnosed from cells in asetic fluid.
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 4, 1957, to April 24, 1957, that I last saw the deceased alive on April 24, 1957, and that death occurred at 4:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: T. Vestal M.D.
ADDRESS (Street, city or town, state): Henryton, Maryland
DATE SIGNED: 4-24-57

PHYSICIAN'S NAME (Type): Dr. Tom F. Vestal, Supt. Henryton State Hospital, Henryton, Md.

22a BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: Mt. M. Cemetery Board

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Frank D. Russell
ADDRESS: Reisterstown, Md.

24a. REC'D BY REGISTRAR DATE: 4-29-57

24b. REGISTRAR'S SIGNATURE: Albert R. Swanborne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03903

3902 CERTIFICATE OF DEATH

Reg. Dist. No. 76

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
c. LENGTH OF STAY IN 1b: 3 days visiting
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer Park Road

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: XXX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3715 Mary Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Gertrude — Middle O. — Last Fitz
4. DATE OF DEATH: Month April — Day 25 — Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 15, 1880
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Orange Co., Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Tayler
14. MOTHER'S MAIDEN NAME: Margaret Keenan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: John B. Fitz, RFD 1, Finksburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Decompensated Arteriosclerosis C-V Disease — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs.
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Nephritis
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): none
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): none
20c. TIME OF INJURY Hour o. m. p. m. / Month, Day, Year: none 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐: none
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none
20f. (City or town) (County) (State): none

21. I certify that I attended the deceased from Apr. 23, 1957, to Apr. 25, 1957 that I last saw the deceased alive on Apr. 24, 1957, and that death occurred at 4 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: D. D. Caples, M.D. — ADDRESS (Street, city or town, state): 6 Hanover Rd. — DATE SIGNED: 4-26-57

PHYSICIAN'S NAME (Type): D. D. Caples, M. D. — Reisterstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Interment
22b. DATE THEREOF: April 27, 1957
22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
22d. LOCATION (City, town, or county) (State): Randallstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS:

24a. REC'D BY REGISTRAR DATE: 4-28-57
24b. REGISTRAR'S SIGNATURE: Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [redacted]ral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03904

CERTIFICATE OF DEATH

3903

Reg. Dist. No. 26

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: CARROLL — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FINKSBURG

LENGTH OF STAY (in this place): 70 YRS

HOSPITAL OR INSTITUTION OR STREET ADDRESS: SANDYMOUNT RD.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: MARYLAND COUNTY: CARROLL

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FINKSBURG

STREET ADDRESS (If rural give location): SANDYMOUNT R.D.

3. NAME OF DECEASED (Type or Print): (First) ELLA (Middle) MAE (Last) FLATER

4. DATE OF DEATH: (Month) APRIL (Day) 26 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Female	White	Married	Sept. 28, 1886	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	Own Home	Carroll County, Md.	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John T. Ward	Margaret Devilbiss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no		- - - - - - - - -	F. Marion Flater Finksburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 24 HRS

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) CARCINOMA COLON — 3 YRS.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. ARTERIOSCLEROTIC C.V. DISEASE — 4 YRS.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov. '54	CARCINOMA COLON	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED White at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from APRIL 1, 1957, to APRIL 26, 1957, that I last saw the deceased alive on APRIL 25, 1957, and that death occurred at 4:10 PM, from the causes and on the date stated above.

SIGNATURE Martin E. Stybel M.D. **ADDRESS** (Street, city, town, state) HEISTERSTOWN MD. **DATE SIGNED** 4/26/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-28-57	Sandymount Cemetery	Sandymount, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
4-29-57	Harriet Miller	John R. Byers Westminster, Md.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03905

3904

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MAIN ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X UNION BRIDGE
d. STREET ADDRESS: MAIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First GEORGE Middle STERLING Last FOGLE

4. DATE OF DEATH: Month APRIL Day 15 Year 1957

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/30/1919
9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINE OPERATOR
10b. KIND OF BUSINESS OR INDUSTRY: SHOE MFG
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: GEORGE M. FOGLE
14. MOTHER'S MAIDEN NAME: MERLE ERNST

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 218-09-1004
17. INFORMANT: G.M. FOGLE Address: UNION BRIDGE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial degeneration
DUE TO (b): Purulent Bronchitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-8, 1957, to 4-14, 1957, that I last saw the deceased alive on 4-14, 1957, and that death occurred at ___ A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. N. Legg M.D. ADDRESS (Street, city or town, state): Union Bridge, Md DATE SIGNED: 4-15-57

PHYSICIAN'S NAME (Type): T. H. LEGG MD ADDRESS: UNION BRIDGE MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 4/17/57
22c. NAME OF CEMETERY OR CREMATORY: BAUST CEM.
22d. LOCATION (City, town, or county) (State): CARROLL COUNTY MD

23. FUNERAL DIRECTOR'S SIGNATURE: O.N. Hartsfeld Sons, Union Bridge Md ADDRESS:

24a. REC'D BY REGISTRAR DATE: 4/16/57
24b. REGISTRAR'S SIGNATURE: Leslie D. Repp

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

; 3905

CERTIFICATE OF DEATH

03906

Reg. Dist. No. 7

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY CARROLL

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster

c. LENGTH OF STAY IN 1b 74 YRS.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 72 CHARLES

d. STREET ADDRESS 72 CHARLES

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First GEORGE Middle HENRY Last FOWLER

4. DATE OF DEATH Month 4 Day 13 Year 1957

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 2-1-1885 ?

9. AGE (In years last birthday) 74? yrs.

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JAMES FOWLER

14. MOTHER'S MAIDEN NAME JENNY TINGLING

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. 219-07-0983

17. INFORMANT CHARLES M. FOWLER Address 72 CHARLES WESTMINSTER MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia & Cerebral hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) Cardio Vas Disease

DUE TO (c) Hypertension

INTERVAL BETWEEN ONSET AND DEATH Don't know: He was in uremia at time of 1st call

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 X

20d. INJURY OCCURRED While at work ☐ Not while at work ☐ X

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X

20f (City or town) (County) (State) X

21. I certify that I attended the deceased from 4-52, 1952, to 4-13-, 1957, that I last saw the deceased alive on 4-13-, 1957, and that death occurred at 11 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE N. C. Starr M.D.

ADDRESS (Street, city or town, state) 121 E Green St. Westminster Md

DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 4-16-1957

22c. NAME OF CEMETERY OR CREMATORY WESTMINSTER CEM.

22d. LOCATION (City, town, or county) (State) WESTMINSTER, MD

23. FUNERAL DIRECTOR'S SIGNATURE David A. Bankard ADDRESS Westminster

24a. REC'D BY REGISTRAR DATE 4-16-57

24b. REGISTRAR'S SIGNATURE Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03907

CERTIFICATE OF DEATH

3906

Reg. Dist. No. 74

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Price, Maryland
d. STREET ADDRESS: c/o P.O.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First George — Middle Hezekiah — Last Gibbs

4. DATE OF DEATH: Month April — Day 4 — Year 1957

5 SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-12-1888

9 AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Hayden, Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Abraham Gibbs

14. MOTHER'S MAIDEN NAME: Sarah Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 221-14-8414A

17 INFORMANT — Address: Viola G. Henry - 116½ E. 13th St., Chester, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiovascular Insufficiency — INTERVAL BETWEEN ONSET AND DEATH:

002X

DUE TO (b): Far Advanced Bilateral Pulmonary Tuberculosis — Mid 1956

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): with Cavitation

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 12, 1957, to April 4, 1957, that I last saw the deceased alive on April 4, 1957, and that death occurred at 12:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: T. F. Vestal M.D. — ADDRESS (Street, city or town, state): Henryton, Maryland — DATE SIGNED: 4-4-57

PHYSICIAN'S NAME (Type): T. F. Vestal, Supt. — Henryton State Hospital, Henryton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/7/57

22c. NAME OF CEMETERY OR CREMATORY: Church Hill

22d. LOCATION (City, town, or county) (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane — ADDRESS: Church Hill Md

24a. REC'D BY REGISTRAR DATE: 4-4-57

24b. REGISTRAR'S SIGNATURE: Albert R. Swanborn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03908

3907

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R 1 Brown Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
d. STREET ADDRESS: R 1 Brown Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Isaac — Last: Green

4. DATE OF DEATH: Month: April — Day: 23 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 3, 1900

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationary Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Congoleum Mfg.

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Dennis Green

14. MOTHER'S MAIDEN NAME: Grace Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): — — — — —

16. SOCIAL SECURITY NO.: 216-07-3850

17. INFORMANT: Mrs. Etta A. Green — Address: R 1 Finksburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Several Days
DUE TO
(b): Coronary Sclerosis — several mo.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 23, 1957, to April 23 1957, that I last saw the deceased alive on April 23, 1957, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilem Speicher M.D. — ADDRESS (Street, city or town, state): Westminster Md — DATE SIGNED: 4/24/57

PHYSICIAN'S NAME (Type): W. G. Speicher, M.D. — 135 E. Main St. Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-26-57
22c. NAME OF CEMETERY OR CREMATORY: Evergreen Mem. Garden
22d. LOCATION (City, town, or county) (State): Finksburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John R. Byers — ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: 4-25-57
24b. REGISTRAR'S SIGNATURE: Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3908 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03909

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Uniontown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Uniontown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Alverta — Middle: Stuller — Last: Haines

4. DATE OF DEATH: Month: April — Day: 29 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 18, 1894

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John S. Stuller

14. MOTHER'S MAIDEN NAME: Annie Nelson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hilbert Stuller, Showell, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): SUFFALATION - By Hanging — INTERVAL BETWEEN ONSET AND DEATH: minutes

974 X

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Hanged by neck

20c. TIME OF INJURY: Hour: 7 a. m. — Month, Day, Year: 4-29-1957

20d. INJURY OCCURRED: White at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Uniontown (County) Carroll (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒; and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4/29/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 2, 1957

22c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery

22d. LOCATION (City, town, or county) (State): Uniontown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Merwyn C. Fuss
Merwyn C. Fuss — ADDRESS: Taneytown, Maryland

24a. REC'D BY REGISTRAR DATE: MAY 1 1957

24b. REGISTRAR'S SIGNATURE: A. H. Hedrick

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

→ 3909 **CERTIFICATE OF DEATH**

Reg. Dist. No. 03910 77

1 PLACE OF DEATH
a COUNTY: Carroll — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: Since 1-8-1911
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: Unk
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: E. Last: HARPER
4. DATE OF DEATH: Month: April Day: 11 Year: 1957

5 SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: ?
9 AGE (If under 1 year Months, Days; If under 24 hrs Hours, Min.): 76 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teamster
10b KIND OF BUSINESS OR INDUSTRY: Unk
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Harper
14 MOTHER'S MAIDEN NAME: Ida Wilkerson

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT: Records of Springfield State Hospital Address: Sykesville, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b) Erysipelas of left leg — 9 days
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 026X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): General Paresis. Central Nervous System Syphilis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 8, 1911, to April 11, 1957, that I last saw the deceased alive on April 11, 1957, and that death occurred at 11:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Gross M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 4-11-57

PHYSICIAN'S NAME (Type): Martin Gross, M. D. Sykesville, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-12-57
22c. NAME OF CEMETERY OR CREMATORY: Springfield
22d. LOCATION (City, town, or county) (State): Sykesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Haight ADDRESS: Sykesville, Md.
24a. REC'D BY REGISTRAR DATE: 4-12-57
24b. REGISTRAR'S SIGNATURE: Tiffany Dove

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: [illegible] after this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be [illegible] filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03911

3910 CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMPSTEAD
c. LENGTH OF STAY IN 1b 5 mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 134 S MAIN St

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead Md
d. STREET ADDRESS 1 134 S Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Anna Middle: Virginia Last: HARRIS

4. DATE OF DEATH Month: April Day: 2 Year: 1957

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Nov 30 1870

9. AGE (In years last birthday) 86 yrs.

IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Theodore Jacob Troxell

14. MOTHER'S MAIDEN NAME Emma Chenoweth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO —

17. INFORMANT Address: Thos E Harris Hampstead Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis.
DUE TO
(b) Hypertensive Cardio-Vascular Disease.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 —

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 25, 19 56, to April 2, 19 57, that I last saw the deceased alive on March 30, 19 57, and that death occurred at 1 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Joseph E. Bush M.D. ADDRESS (Street, city or town, state) Hampstead Md DATE SIGNED 4/2/57

PHYSICIAN'S NAME (Type) Joseph E Bush MD Hampstead Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Buried

22b. DATE THEREOF April 5/57

22c. NAME OF CEMETERY OR CREMATORY Graves Run

22d LOCATION (City, town, or county) Balto Co (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Edw C Tipton, ADDRESS Hampstead Md

24a. REC'D BY REGISTRAR DATE 4/7/57

24b. REGISTRAR'S SIGNATURE Henry J Reed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03912

3911 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Sykesville, Maryland
c. LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 413 Calvin Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella — Middle: Belle — Last: Haupt

4. DATE OF DEATH: Month: 4 — Day: 4 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-20-1881

9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager

10b. KIND OF BUSINESS OR INDUSTRY: Cafeteria

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edgar Lankford

14. MOTHER'S MAIDEN NAME: Ella Belle Overton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: Unk

17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized arteriosclerosis — years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 13, 1957, to April 4, 1957, that I last saw the deceased alive on April 4, 1957, and that death occurred at 11:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gertrude M. Gross, M.D. M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED:

PHYSICIAN'S NAME (Type): Gertrude M. Gross, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-8-57

22c. NAME OF CEMETERY OR CREMATORY: Loudon Pk.

22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible]

24a. REC'D BY REGISTRAR — DATE: 4-4-57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
IBM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03913

3912 CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3mo. 2days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 31 S. Cannon Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Harvey Middle: Elaine Last: [illegible]

4 DATE OF DEATH: Month: April Day: 2 Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-19-80
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Pennsylvania
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Hertzler
14. MOTHER'S MAIDEN NAME: Sara

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): C (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: not known
17. INFORMANT: Records from Address: Springfield State Hospital - Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	Minutes
DUE TO	Pulmonary Emphysema	Approx. 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (b)	Enlargement of the Heart	
DUE TO (c)	Generalized Arteriosclerosis	10 years+

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 4, 1956, to April 2, 1957, that I last saw the deceased alive on April 2, 1957, and that death occurred at 3:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Gross M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 4-3-57

PHYSICIAN'S NAME (Type): MARTIN GROSS, M.D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-5-57
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill
22d LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Fred W. Kraiss Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: 4-4-57
24b. REGISTRAR'S SIGNATURE: C. Murray Zeller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03914
(03914)

3913 CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution· Residence before admission)
a. STATE: Maryland b COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b: 10 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] Silver Spring

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d STREET ADDRESS: 808 Silver Spring Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Joseph Middle Thomas Last HEWITT

4 DATE OF DEATH: Month April Day 24 Year 1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
M	W		July 23, 1870	86 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
~~Unknown~~ Meter Reader	Sub. San. Commission	Canada	USA

13. FATHER'S NAME: Richard Hewitt

14 MOTHER'S MAIDEN NAME: Julie Dowling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	—	Unk.	Springfield Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years

400.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with senile brain disease. Broncho-pneumonia.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 13, 1957 to April 24, 1957 that I last saw the deceased alive on April 24, 1957, and that death occurred at 6:30 A.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 4/24/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. Sykesville, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	4/26/57	Rockville Cemetery	Rockville, Montgomery Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey ADDRESS: Silver Spring, Md.

24a. REC'D BY REGISTRAR DATE: 4-27-57 24b. REGISTRAR'S SIGNATURE: C Harry Eller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3914

CERTIFICATE OF DEATH

03915

Reg. Dist. No. 7

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster RD #5
c. LENGTH OF STAY IN 1b 4 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Town Road

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster RD #6
d. STREET ADDRESS Gastonia
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print) First WILLIAM Middle CLAUTICE Last HILL

4. DATE OF DEATH Month April Day 20 Year 1957

5 SEX Male
6 COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH April 17, 1880
9 AGE (In years last birthday) 77 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME John Thomas Hill
14. MOTHER'S MAIDEN NAME Victoria Clautice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO. 213-14-3126
17 INFORMANT Address Morgan W. Hill, Westminster Md RD#6

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH abt 10 min
DUE TO (b) Arteriosclerosis — 3+ yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 19 54 to Apr. 20, 19 57, that I last saw the deceased alive on Apr. 12, 19 57, and that death occurred at 11:45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE, M.D. F. Reese Wilkens — ADDRESS (Street, city or town, state) 15 Kenwood Westminster — DATE SIGNED 4/22/57

PHYSICIAN'S NAME (Type) F. REESE WILKENS

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF April 23/57
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
22d LOCATION (City, town, or county) (State) Silver Run, Carroll Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. E. Myers Jr. Westminster Md
24a REC'D BY REGISTRAR DATE 4-22-57
24b REGISTRAR'S SIGNATURE Harold Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3915 CERTIFICATE OF DEATH

Reg. Dist. No. 03916

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Uniontown
c. LENGTH OF STAY IN 1b: 35 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Uniontown
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: E. — Last: Hoch

4. DATE OF DEATH: Month: April — Day: 7 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 12, 1894

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel W. Carman

14. MOTHER'S MAIDEN NAME: Rebecca Jane Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Rev. John H. Hoch, Uniontown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cancer of ear (left) — INTERVAL BETWEEN ONSET AND DEATH: 2½ yrs

160X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 4, 1957 to April 7, 1957 that I last saw the deceased alive on April 6, 1957 and that death occurred at 10 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: D. N. Legg M.D. ADDRESS (Street, city or town, state): Union Bridge Md DATE SIGNED: 4-8-57

PHYSICIAN'S NAME (Type): T. H. LEGGETT MD UNION BRIDGE MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 9, 1957

22c. NAME OF CEMETERY OR CREMATORY: Church of God Cemetery

22d. LOCATION (City, town, or county) (State): Uniontown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Merwyn C. Fuss ADDRESS: Taneytown, Maryland

24a. REC'D BY REGISTRAR DATE: APR 10 1957

24b. REGISTRAR'S SIGNATURE: T. H. Bedsuch

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 19 film [illegible] et

3916

03917

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4 mos, 23 dys
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 24
d. STREET ADDRESS: 227 North Curley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle Ernest — Last HOWALD

4. DATE OF DEATH: Month April — Day 2 — Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 16, 1890

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gas Station Attendant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Switzerland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fritz Howald

14. MOTHER'S MAIDEN NAME: Mary Ann --

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 222-03-9175

17. INFORMANT: Springfield Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Acute pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO (b): Thrombi about infected urinary bladder — weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Bronchopneumonia — days

Chronic nephrosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 2, 1956 to April 2, 1957 that I last saw the deceased alive on April 2, 1957, and that death occurred at 10:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 4/3/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/6/57
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park
22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE: Philip Henry Sons
ADDRESS: 2024 Orleans St

24a. REC'D BY REGISTRAR DATE: APR 5 1957
24b. REGISTRAR'S SIGNATURE: C. Harry Hays

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05047

3917

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5yrs.7mos.4days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City (24)
d. STREET ADDRESS: Highland Avenue. 1001 S. [redacted]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle George — Last KLEIN

4. DATE OF DEATH: Month April — Day 30 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/23/08

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Workman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: August Klein

14. MOTHER'S MAIDEN NAME: Barbara Welsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Springfield State Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) [redacted] — INTERVAL BETWEEN ONSET AND DEATH [redacted]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Acute Myocardial Infarction — minutes

DUE TO (c) Coronary Arteriosclerosis — Months

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, paranoid type.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): James T. Marsh, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4/30/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-13-57

22c. NAME OF CEMETERY OR CREMATORY: Balto. National Cem.

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Edward [illegible] ADDRESS

24a. REC'D BY REGISTRAR DATE 5/15/57

24b. REGISTRAR'S SIGNATURE: C. Harry [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to interment, or removal.

VS. A15ME(5)
SM 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3918 CERTIFICATE OF DEATH

03918

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 yr. 10 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sprin[illegible]field State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 853 Eutaw Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Phoebe; Middle: Elizabeth; Last: Lawson

4. DATE OF DEATH: Month: April; Day: 25; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7-30-77

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ruben Cassidy

14. MOTHER'S MAIDEN NAME: Catherine J.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: years

443 X

DUE TO (b): Generalized arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS (Chronic brain syndrome) associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-14, 1955, to 4-25, 1957, that I last saw the deceased alive on 4-25, 1957, and that death occurred at 1:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gertrud Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 4/25/57

PHYSICIAN'S NAME (Type): Gertrud Sonnenfeldt
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 4-29-57

22c. NAME OF CEMETERY OR CREMATORY: [illegible] Baltimore Md.

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Frank H. Newell, Pikesville
ADDRESS:

24a. REC'D BY REGISTRAR
DATE: 4/30/57

24b. REGISTRAR'S SIGNATURE: C. Harry Haus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3919

CERTIFICATE OF DEATH

03919

Reg. Dist. No. 82

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2 Mt. Airy
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle E. — Last LILLY

4. DATE OF DEATH: Month April — Day 22 — Year 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Aug. 2, 1894

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Real Estate

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert E. Lilly

14. MOTHER'S MAIDEN NAME: ? Morris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 215-14-6959

17. INFORMANT — Address: Robert Lilly, Waynesboro, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Several Years

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September, 1956, to April, 1957, that I last saw the deceased alive on About April 1, 1957, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W.B. Culwell M.D. — ADDRESS (Street, city or town, state): Mt Airy, Md. — DATE SIGNED: 4/22/57

PHYSICIAN'S NAME (Type): W.B. Culwell

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4-25-1957

22c. NAME OF CEMETERY ~~OR CREMATORY~~: Mt. View

22d. LOCATION (City, town, or county) (State): Howard Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: C. M. Waltz, Winfield, Maryland

24a. REC'D BY REGISTRAR DATE 4/26/57

24b. REGISTRAR'S SIGNATURE: Edna Hewitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3920 CERTIFICATE OF DEATH

Reg. Dist. No. 03920 177

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 6 3Y01-4
d. STREET ADDRESS: 4504 Woodlea Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Margaret; Middle; Last LITTLE

4. DATE OF DEATH: Month April; Day 3; Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 21, 1872

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry - BETZEL

14. MOTHER'S MAIDEN NAME: Margaret -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive cardiovascular disease — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 16, 1957, to April 3, 1957, that I last saw the deceased alive on April 3, 1957, and that death occurred at 7:30 AM, from the causes and on the date stated above

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield Hospital
DATE SIGNED: 4/3/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: April 6 '57
22c. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: Ulrich Funeral Home Balto. Md.

24a. REC'D BY REGISTRAR DATE: 4-3-57

24b. REGISTRAR'S SIGNATURE: C Strong Wilson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3921 CERTIFICATE OF DEATH

03921 74
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 11yrs.9mos.24days

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Catonsville, 28,

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital
d. STREET ADDRESS: 400 Hazlett Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: E. Last: McCLANAHAN
4. DATE OF DEATH: Month: April Day: 24 Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 7,1912
9. AGE (In years last birthday): 44 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William E. McClanahan
14. MOTHER'S MAIDEN NAME: Susie McGuinness

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Sub-acute glomerulonephritis — INTERVAL BETWEEN ONSET AND DEATH: weeks

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenia, hebephrenic type. Bronchopneumonia.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1950, to April 24, 1957, that I last saw the deceased alive on April 24, 1957, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 4/27/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/26/57
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
22d. LOCATION (City, town, or county) (State): Balto., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Dickner & Sons-Balto 17,
ADDRESS: 2400
24a. REC'D BY REGISTRAR DATE: APR 29 1957
24b. REGISTRAR'S SIGNATURE: C. Henry Keers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03922

3922 CERTIFICATE OF DEATH Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY Carrol MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Longview Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Carrol
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneyboro
STREET ADDRESS (If rural give location) Taneyboro

3. NAME OF DECEASED (Type or Print): (First) FRANKLIN (Middle) H. (Last) MILLER
4. DATE OF DEATH: (Month) April (Day) 18 (Year) 1957
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 3/21/78
9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Merchant
10b. KIND OF BUSINESS OR INDUSTRY: General store
11. BIRTHPLACE (State or foreign country): Adams Co. Pa
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Albert Miller
14. MOTHER'S MAIDEN NAME: Jane Baker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: ✓
17. INFORMANT & ADDRESS: Ralph Miller Taneyboro, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death
Immediate cause (a) Arteriosclerotic Heart Disease — 5 yrs
DUE TO
Antecedent causes (s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1949, to April 18, 1957, that I last saw the deceased alive on April 17 1957, and that death occurred at 3.00 AM, from the causes and on the date stated above.
SIGNATURE W H Foard (Degree or title) M.D. ADDRESS Manchester Md DATE SIGNED 4/19/57

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 4/21/57 NAME OF CEMETERY OR CREMATORY Stone Church LOCATION (City, town, or county) (State) Bendbeck R.D. York Pa

DATE REC'D BY LOCAL REGISTRAR Apr. 19-57 REGISTRAR'S SIGNATURE Mrs W. H. Dormer
24. FUNERAL DIRECTOR H. Gleffler & Son ADDRESS Glen Rock Pa
H Gleffler

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3923 Items 2, 1a [illegible]

CERTIFICATE OF DEATH

03923

Reg. Dist. No. 76

In P.T. (-214 [illegible])

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FINKSBURG
c. LENGTH OF STAY IN 1b: 3 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CEDARHURST R.D.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: California
b. COUNTY: VENEZUELA STATE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Los Angeles
d. STREET ADDRESS: 3319 Military Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First CHARLES Middle [illegible] Last MOORE

4. DATE OF DEATH: Month APRIL Day 18 Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 7-22-1899

9. AGE (In years last birthday): 57 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: Ret. Fields

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: HERBERT MOORE

14. MOTHER'S MAIDEN NAME: CATHERINE FIELDS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 550-09-3715

17. INFORMANT: Address: MRS. J. B. SPENCER FINKSBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma mandible, Mt.

DUE TO: & L lung

191.x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb, 1957, to Apr 18, 1957, that I last saw the deceased alive on Apr 18, 1957, and that death occurred at 11:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm C. Jennette M.D. ADDRESS (Street, city or town, state): 105 E Main Westminster Md DATE SIGNED: 4-20-57

PHYSICIAN'S NAME (Type): Wm Carl Jennette 105 E Main Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4-21-1957

22c. NAME OF CEMETERY OR CREMATORY: METHODIST CEM.

22d. LOCATION (City, town, or county) (State): FINKSBURG MD.

23. FUNERAL DIRECTOR'S SIGNATURE: David C. Bankard ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: 4-24-57

24b. REGISTRAR'S SIGNATURE: Hamit Mills

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03924

3924

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 50 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Belair
d. STREET ADDRESS: 15 Lee Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ellsworth — Middle: Westley — Last: Moore

4. DATE OF DEATH: Month: April — Day: 20 — Year: 1957

5. SEX: Male — Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: November 8, 1895

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Mark Moore

14. MOTHER'S MAIDEN NAME: Isabella Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-14-3270

17. INFORMANT: Address: Ellsworth W. Moore - 15 Lee Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro-vascular disease — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Syphilis or Tuberculosis

DUE TO

(c) Pulmonary Tuberculosis, far advanced

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 12, 1957, to April 20, 1957, that I last saw the deceased alive on April 20, 1957, and that death occurred at 12:30 M., from the causes and on the date stated above.

ACTUAL SIGNATURE: T. F. Vestal M.D. — ADDRESS (Street, city or town, state): Henryton, Maryland — DATE SIGNED: 4-19-57

PHYSICIAN'S NAME (Type): T. F. Vestal, Superintendent, Henryton State Hospital, Henryton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/23/57

22c. NAME OF CEMETERY OR CREMATORY: Tabernacle Cemetery

22d. LOCATION (City, town, or county) (State): Benson, Md. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Booker & Wilson — ADDRESS: 530 [illegible]

24a. REC'D BY REGISTRAR DATE: 4-22-57

24b. REGISTRAR'S SIGNATURE: Albert R. Swanstrom

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) ISM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03925

CERTIFICATE OF DEATH

3925

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: since 3-5-56
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonsboro 21x
d. STREET ADDRESS: Route #2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Joshua — Middle Elias — Last MOSER

4. DATE OF DEATH: Month April — Day 23 — Year 1957

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: September 12, 1873
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Farmer and wood worker
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Ezra Moser
14. MOTHER'S MAIDEN NAME: Roseann Itnyre

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Records of Springfield State Hospital
Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): HYPOSTATIC LOBAR Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
490 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): General arteriosclerosis — over 10 yrs
DUE TO (c): Marked dehydration — 1 month

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C B S. prost. C. senile brain disease C. prostatic neoplasm
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ---
20c. TIME OF INJURY: Hour — a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from March 5th, 1956, to April 23, 1957, that I last saw the deceased alive on April 22, 1957, and that death occurred at 5:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Gross M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 4-23-57

PHYSICIAN'S NAME (Type): Martin Gross, M. D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: April 25 1957
22c. NAME OF CEMETERY OR CREMATORY: Fahrney's Cemetery
22d. LOCATION (City, town, or county) (State): Nr. Mapleville Wash. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: East Funeral Home Boonsboro Maryland
24a. REC'D BY REGISTRAR DATE: 4/29/57
24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and the entire certificate should be filed with the registrar within 72 hours after death.

VS ATS (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3926 CERTIFICATE OF DEATH

03926 74 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 7 mos, 17 dys
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Spencerville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Hanley — Middle James — Last MULLIN

4. DATE OF DEATH: Month April — Day 9, — Year 19 57

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: December 7, 1885

9. AGE (In years last birthday): 71 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: GEN. BLDG TRADES

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Mullin

14. MOTHER'S MAIDEN NAME: Martha Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: 577-26-4274

17. INFORMANT — Address: Springfield Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 903.1

DUE TO (b): Decubitous ulcer — weeks

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture right hip. CBS assoc. with cerebral arteriosclerosis with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [X] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Slipped and fell as he stepped from shower in bathroom.

20c. TIME OF INJURY: Hour 5:45 [X] a.m. [ ] p.m. — Month 3 — Day 6 — Year 57

20d. INJURY OCCURRED: While at work [ ] Not while at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital ward

20f. (City or town) Sykesville (County) Carroll (State) Md.

21. I certify that I attended the deceased from August 22, 1956, to April 9, 1957, that I last saw the deceased alive on April 9, 1957, and that death occurred at 6:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 4/9/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: April 11, 1957

22c. NAME OF CEMETERY OR CREMATORY: GEORGE WASHINGTON CEM

22d. LOCATION (City, town, or county) (State): RIGGS Rd. HYATTSVILLE Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Arthur L. Fallery — ADDRESS: 254 CARROLL ST. N.W.

24a. REC'D BY REGISTRAR DATE: APR 11 1957

24b. REGISTRAR'S SIGNATURE: C. Barry Keene

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03927

3927 CERTIFICATE OF DEATH

Reg. Dist. No. 777

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1 PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE: Maryland b. COUNTY:
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville	c. LENGTH OF STAY IN 1b: 38yr,8mo,11dy
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital	d. STREET ADDRESS: 9 East Lafayette Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒	

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mary	L.	MUTH	April 18,		19 57

5. SEX	6. COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
F	W		May 27, 1886	70 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Traveling Saleslady	stove company	Maryland	USA

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
George W. Muth	Sallie R. Tracey

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO.	17. INFORMANT Address
No	—	-Unk.	Springfield Hospital records

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary tuberculosis, minimal, active	4 years
0022 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia, hebephrenic type. Diabetes.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 20, 1954, to April 18, 1957, that I last saw the deceased alive on April 18, 1957, and that death occurred at 3:00P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund B. Lusthaus M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 4/18/57

PHYSICIAN'S NAME (Type): Edmund B. Lusthaus, M.D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
BURIAL	4-22-57	Bosley Methodist Cemetery	Baltimore County, Md

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
William Cook, Inc., 1217 St. Paul Street	4-19-57	C Harry Eckert

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3928

Reg. Dist. No. 0392874

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Maryland
b. COUNTY Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Wood
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF [redacted] (Type or print): First GEORGE Middle ALBERT Last MYERS

4. DATE OF DEATH: Month April Day 11 Year 1957

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 10, 1884

9. AGE (In years last birthday) [illegible] yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Nursery

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Myers

14. MOTHER'S MAIDEN NAME: Julia Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-22-0276

17. INFORMANT: Lena Myers — Address: Gaithersburg, Md. R.F.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, Coronary Thrombosis, — INTERVAL BETWEEN ONSET AND DEATH: Jan 57

DUE TO (b) Auricular Fibrillation, Arteriosclerosis, — Jan 57

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertension, Obesity — April 57

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1957, to 11 April, 1957, that I last saw the deceased alive on 11 April, 1957, and that death occurred at 10:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Howard E. Hall M.D. ADDRESS (Street, City or town, state) Sykesville, Md. DATE SIGNED 11 April 57

PHYSICIAN'S NAME (Type) Howard E. Hall

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/15/57

22c. NAME OF CEMETERY OR CREMATORY: Bush Park,

22d. LOCATION (City, town, or county) (State): Cookesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Sandler — ADDRESS: Cookesville, Md.

24a. REC'D BY REGISTRAR DATE: APR 18 1957

24b. REGISTRAR'S SIGNATURE: C. Harry Hess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03929

3929 CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Westminster
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Westminster, Md. R.D.1 (Silver Run)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Westminster
d. STREET ADDRESS: Westminster, Md. R.D.1 (Silver Run)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Jacob — Middle David — Last Petry

4. DATE OF DEATH: Month April — Day 15 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: February 2, 1874

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: His own farm

11. BIRTHPLACE (State or foreign country): Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph G. Petry

14. MOTHER'S MAIDEN NAME: Catherine Starner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-20-2469

17. INFORMANT: Chester A Petry — Address: Chester A. Petry, R.D.1, Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): My. cardiosclerosis (old)
DUE TO
(c): Hypertension (old)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1956, to Apr 15, 1957, that I last saw the deceased alive on Apr 15, 1957, and that death occurred at 8:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. C. Jeannette M.D. — ADDRESS (Street, city or town, state): 1035 Main Westminster Md — DATE SIGNED: 4-16-57

PHYSICIAN'S NAME (Type): Wm Carl Jeannette MD — Asst Examiner Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 18, 1957

22c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery

22d. LOCATION (City, town, or county) (State): Silver Run, Carroll Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard A Little — ADDRESS: Littlestown, Pa.

24a. REC'D BY REGISTRAR DATE: 4-16-57

24b. REGISTRAR'S SIGNATURE: Harriet Mullen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03930

3930 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville — c. LENGTH OF STAY IN 1b: 12 yrs, 5 dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Jacob	William	Reichelt	April	16,	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
M	W		November 5, 1899	57 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Glass blower	Glass Factory	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Adolph Reichelt	Elizabeth Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	-	Unk.	Springfield Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Syphilis of the central nervous system — INTERVAL BETWEEN ONSET AND DEATH: years

094 X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with syphilitic meningo-encephalitis. Cirrhosis of the liver. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1950, to April 16, 1957, that I last saw the deceased alive on April 16, 1957, and that death occurred at 8:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 4/17/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Embalming	22b. DATE THEREOF: 4-17-57	22c. NAME OF CEMETERY OR CREMATORY: Mt. Fred Med Edwd	22d. LOCATION (City, town, or county) (State): Baltimore, Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR DATE: 4-18-57 — 24b. REGISTRAR'S SIGNATURE: C. Henry Myers

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03931

3931

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4 mos, 15 dys
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4501 Cortland Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Edwin — Last: ROSE

4. DATE OF DEATH: Month: April — Day: 12, — Year: 19 57

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 2, 1921

9. AGE (In years last birthday): 36 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: - Yuk

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edwin J. Rose

14. MOTHER'S MAIDEN NAME: Ruth DeFrehn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: Yuk

17. INFORMANT: Springfield Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute interstitial pneumonitis, right lung — INTERVAL BETWEEN ONSET AND DEATH: days

52 5X

DUE TO (b): Acute collapse of the right lung — day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with congenital spastic paraplegia with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 27, 19 56, to April 12, 19 57, that I last saw the deceased alive on April 12, 19 57, and that death occurred at 7:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 4/12/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-15-57

22c. NAME OF CEMETERY OR CREMATORY: Grand View

22d. LOCATION (City, town, or county) (State): Johnstown Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Keith A Haight — ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: 4-14-57

24b. REGISTRAR'S SIGNATURE: C Avery Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03932

3932

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 9 months 28dys
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital.

2. USUAL RESIDENCE (Where deceased lived If inst'tution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City 311
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 717 W.36th.st.Baltimore 11
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle Jacob — Last Sieck

4. DATE OF DEATH: Month 4 — Day 27 — Year 1957

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-26-91

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Eugene Sieck
14. MOTHER'S MAIDEN NAME: Georana McBunnin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 217-01-3377
17. INFORMANT — Address: Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: days

420.0

DUE TO (b): Coronary Thrombosis — days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerotic heart disease. — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome with C.A.S.without qualifying phrase

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-29-56, to 4-27-57, that I last saw the deceased alive on 4-27-57, and that death occurred at 11.50p.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital. — DATE SIGNED: 4-28-57

PHYSICIAN'S NAME (Type): Agustin del Campo M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-1-57
22c. NAME OF CEMETERY OR CREMATORY: Mon. Cemetery
22d. LOCATION (City, town, or county) (State): Ballastown Co

23. FUNERAL DIRECTOR'S SIGNATURE: Frank H Seitz — ADDRESS: 814 W 36th St

24a. REC'D BY REGISTRAR DATE: 4/30/57
24b. REGISTRAR'S SIGNATURE: C. Harry Keen

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03933

CERTIFICATE OF DEATH

3933

Reg. Dist. No. 74

1 PLACE OF DEATH
a. COUNTY Carroll MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b COUNTY Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville

c. LENGTH OF STAY IN 1b 3 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital

d STREET ADDRESS 10212 Haywood Drive

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Smith

4 DATE OF DEATH Month April Day 2 Year 19 57

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 3-15-81

9. AGE (In years last birthday) 76 yrs.

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ? —— Feeheley

14. MOTHER'S MAIDEN NAME ~~Unknown~~ MARY HAMMELMANN

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Address Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH 2 weeks plus

DUE TO (b) Arteriosclerotic cardiovascular disease — Years

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c)

4 2 4.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 8-14 19 53, to 4-2 19 57, that I last saw the deceased alive on 4-2 19 57, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Bertrand Sommerfeld M.D. ADDRESS (Street, city or town, state) Springfield State Hospital Sykesville Md. DATE SIGNED 4/2/57

PHYSICIAN'S NAME (Type) Bertrand Sommerfeld M.D. Springfield State Hospital Sykesville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 4/5/57

22c NAME OF CEMETERY OR CREMATORY WASH. NAT'L. CEMETERY

22d LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE Apr. 8, 1957

24b. REGISTRAR'S SIGNATURE C. Henry Edelin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4) 15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03934

3934

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital.

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard 151
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
d. STREET ADDRESS: Dept. of Mental Hygiene Central Farm
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First: Minnie — Middle: Huseby — Last: Sorflaten

4. DATE OF DEATH: Month: 4- — Day: 13 - — Year: 1957

5 SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 5-19-1878
9 AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: Unk
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Arne A.Huseby
14. MOTHER'S MAIDEN NAME: Syneva Huseby-nee Hukee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

420.0

DUE TO (b): Generalized arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 904.7

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Involutional Psychotic reaction.Fracture rt.Femur.Diabetis Mellitus

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [X] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): She said to have fallen on the floor

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.: Unknown 2 - 27-1957
20d INJURY OCCURRED While at work [ ] Not while at work [X]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital
20f. (City or town) (County) (State): Sykesville Carroll Md.

21. I certify that I attended the deceased from 11-15- 1955 to 4- 13 - 1957 that I last saw the deceased alive on 4- 13 - 1957, and that death occurred at 5.30p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 4-14-57

PHYSICIAN'S NAME (Type): Agustin del Campo M.D. — Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-18-57
22c. NAME OF CEMETERY OR CREMATORY: Little Cedar Bottom
22d. LOCATION (City, town, or county) (State): Ellicott, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Arthur M Haight — ADDRESS: Sykesville, Md
24a. REC'D BY REGISTRAR DATE: 4-15-57
24b. REGISTRAR'S SIGNATURE: C Harry Euler

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03935

3935 CERTIFICATE OF DEATH

Reg. Dist. No. 26

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R. 4 Reese

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster
d. STREET ADDRESS: R. 4 Reese
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Florence — Middle Ann — Last Sprinkle
4. DATE OF DEATH: Month April — Day 5 — Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 9, 1868
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Carroll County, Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John H. Taylor
14. MOTHER'S MAIDEN NAME: Margaretta Magee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: - - - - - -
17. INFORMANT: Mrs. Carroll Taylor — Address: Carrollton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Edema of lungs — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Chronic myocarditis — 5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): acute respiratory infection — 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-2, 1957 to 4-5, 1957, that I last saw the deceased alive on 4-4, 1957, and that death occurred at 4 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C L Billingslea M.D. — ADDRESS (Street, city or town, state): Westminster, Md. — DATE SIGNED: 4-5-57
PHYSICIAN'S NAME (Type): C. L. Billingslea, M.D. — 1 S. South Center St. Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-7-1957
22c. NAME OF CEMETERY OR CREMATORY: Carrollton Church of God
22d. LOCATION (City, town, or county) (State): Carrollton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John R. Byers — ADDRESS: Westminster, Md.
24a. REC'D BY REGISTRAR DATE: 4-8-57
24b. REGISTRAR'S SIGNATURE: Hamit Mills

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be [illegible] for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15[illegible] 9/[illegible]

1 W M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3936 CERTIFICATE OF DEATH

03936

Reg. Dist. No. 74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 yr., 4 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sprin field Sta e Hospital

2 USUAL RESIDENCE (Where deceased lived If institution· Residence before admission)
a. STATE: Maryland b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Laurel 13x22
d. STREET ADDRESS: Gorman Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Lilly Middle May Last Stanowsky

4 DATE OF DEATH: Month April Day 9 Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 10-14-74
9 AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Money counter--U.S. Treas.
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Bell
14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ------
17 INFORMANT Address: Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis — Years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with senile brain disease with psychotic reaction
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-25, 19 55, to 4-9, 19 57, that I last saw the deceased alive on 4-9, 19 57, and that death occurred at 10:25 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gertrud Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 4/9/57

PHYSICIAN'S NAME (Type): Gertrud Sonnenfeldt
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-13-57
22c. NAME OF CEMETERY OR ~~CREMATORY~~: Ivy Hill
22d. LOCATION (City, town, or county) (State): Laurel, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson ADDRESS: Laurel, Md.
24a. REC'D BY REGISTRAR DATE: 4-11-57
24b. REGISTRAR'S SIGNATURE: C. Harry Weed

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03937

CERTIFICATE OF DEATH

3880 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 59 Carroll St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 59 Carroll St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Carroll — Middle King — Last Stouch

4. DATE OF DEATH: Month April — Day 5 — Year 1957

5 SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: June 4, 1883
9 AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Painter
10b KIND OF BUSINESS OR INDUSTRY: Bldg. Painter
11 BIRTHPLACE (State or foreign country): Carroll County, Md.
12 CITIZEN OF WHAT COUNTRY? U S A

13 FATHER'S NAME: George Stouch
14. MOTHER'S MAIDEN NAME: Rebecca Bowers

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-14-7986
17. INFORMANT: Mrs. Stella H. Stouch — Address: Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO (b): Generalized Arterio-Sclerosis — 5 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/5 1957 to 4/5 1957 that I last saw the deceased alive on 4/5 1957, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Luther Bare M.D. — ADDRESS (Street, city or town, state): Westminster Maryland — DATE SIGNED: 4/6/57

PHYSICIAN'S NAME (Type): S. Luther Bare, M.D. — 79 W. Main St. Westminster, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Apr. 8, 57
22c. NAME OF CEMETERY OR CREMATORY: Kriders Cemetery
22d LOCATION (City, town, or county) (State): nr Westminster, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: John R. Byers — ADDRESS: Westminster, Md.
24a. REC'D BY REGISTRAR DATE: 4-8-57
24b. REGISTRAR'S SIGNATURE: Harriet Butler

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03938

3881

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 18 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 99 E MAIN

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MD — b COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d STREET ADDRESS: 99 E. MAIN
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle CATHERINE Last SWARTZBAUGH

4. DATE OF DEATH: Month APRIL Day 10 Year 1957

5 SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 11 1919

9. AGE (In years last birthday): 37 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): NEW FREEDOM, PA.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM H. BLESSING

14. MOTHER'S MAIDEN NAME: ANNIE SCHUCHART

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-12-1012

17. INFORMANT: CARROLL O. SWARTZBAUGH Address 99 E MAIN WESTMINSTER MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma Right Breast — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO (b): Mets to Spine

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Anemia & Cachexia

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1 19 57 to April 10 19 57 that I last saw the deceased alive on April 9 19 57 and that death occurred at 4:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Glenn Speicher — ADDRESS (Street, city or town, state): Westminster Md. — DATE SIGNED: 4/11/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4-13-1957

22c. NAME OF CEMETERY OR CREMATORY: MEMORIAL GARDENS CEM.

22d. LOCATION (City, town, or county) (State): FINKSBORG MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward C. Bankard — ADDRESS: Westminster Md.

24a. REC'D BY REGISTRAR DATE 4-16-57

24b. REGISTRAR'S SIGNATURE: Harriet Mullen

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local registrar, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be delivered to the funeral director, filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03939

CERTIFICATE OF DEATH

Reg. Dist. No. 3937

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Taneytown
c. LENGTH OF STAY IN 1b: 47 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ~ Rural Taneytown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: Roop; Last: Teeter

4. DATE OF DEATH: Month: April; Day: 15; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 5, 1886

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Roop

14. MOTHER'S MAIDEN NAME: Celia Utz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Robert C. Clingan, Taneytown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few min.
420.0
DUE TO
(b): Arteriosclerotic Heart Disease — 5 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 26, 1945, to April 15, 1957, that I last saw the deceased alive on April 3, 1957, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. S. McVaugh, M.D. — ADDRESS (Street, city or town, state): 49 Frederick Street-Taneytown, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): R. S. McVaugh

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Apr. 18, 1957

22c. NAME OF CEMETERY OR CREMATORY: Pipe Creek Cemetery

22d. LOCATION (City, town, or county) (State): New Windsor, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Merwyn C. Fuss — ADDRESS: Taneytown, Maryland

24a. REC'D BY REGISTRAR DATE: APR 17 1957

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03940

Reg. Dist. No. 5

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cedarhurst
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2. Cedarhurst
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorothy — Middle: Grace — Last: Trump
4. DATE OF DEATH: Month: April — Day: 30, — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov.23,1926
9. AGE (In years last birthday): 30 yrs.
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Walter F.Sullivan
14. MOTHER'S MAIDEN NAME: Ruth E.Bair

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Clarence C.Trump,Cedarhurst,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion(Acute) — INTERVAL BETWEEN ONSET AND DEATH: 20 min.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ~~XXXX~~ Obesity
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. none
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none
20c. TIME OF INJURY: Hour: o. m. p. m. — Month, Day, Year: none 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D.
EXAMINER'S NAME (Type): James T. Marsh, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-1-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 4/57
22c. NAME OF CEMETERY OR CREMATORY: Finksburg
22d. LOCATION (City, town, or county) (State): Finksburg,Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J.F.Eline & Sons,Reisterstown,Md.
24a. REC'D BY REGISTRAR DATE: 5-2-57
24b. REGISTRAR'S SIGNATURE: Mary B. Eline

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3939 CERTIFICATE OF DEATH

03941
Reg. Dist. No. 75

1 PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead Rural
c. LENGTH OF STAY IN 1b 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland
b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead Rural
d. STREET ADDRESS —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First JOHN Middle W Last Urey
4. DATE OF DEATH Month April Day 4 Year 1957
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH May 21-1870
9. AGE (In years last birthday) 86 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Carpenter
11. BIRTHPLACE (State or foreign country) Penna
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Peter Urey
14. MOTHER'S MAIDEN NAME Eliza Minker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. No
17. INFORMANT Mrs M Halland Address Urey Hampstead Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — Interval between onset and death: 2 mo.
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Arterio-Sclerotic C-V Disease — 2 yrs.
DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 56 to April 4 1957 that I last saw the deceased alive on April 4 1957 and that death occurred at 9:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE M.C. Porterfield M.D. ADDRESS (Street, city or town, state) Hampstead, Md DATE SIGNED 4-4-57
PHYSICIAN'S NAME (Type) M.C.Porterfield Hampstead Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Apr 7-1957
22c. NAME OF CEMETERY OR CREMATORY McKendree
22d. LOCATION (City or town, or county) (State) Oxville Md
23. FUNERAL DIRECTOR'S SIGNATURE Edw E Upton ADDRESS Hampstead Md
24a. REC'D BY REGISTRAR DATE Apr 6/57
24b. REGISTRAR'S SIGNATURE Mrs. H.R.S. Donner

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3940 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03942 76

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural WESTMINSTER
c. LENGTH OF STAY IN 1b 76YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FOUNTAIN VALLEY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER.
d. STREET ADDRESS FOUNTAIN VALLEY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First EFFIE Middle JANE Last WANTZ

4. DATE OF DEATH Month APRIL Day 30 Year 1957

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH SEPT. 28, 1880

9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MD.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME MICHAEL WASHINGTON MYERS

14. MOTHER'S MAIDEN NAME MARY JANE BLACK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Mrs. Roy BASLER Address BALTO. BLVD. WESTMINSTER, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUFFOCATION - BY HANGING — INTERVAL BETWEEN ONSET AND DEATH: MINUTES

4X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) HANGED SELF

20c. TIME OF INJURY Hour 11 a.m. p.m. Month, Day, Year 4-30 1957

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME

20f (City or town) WESTMINSTER (County) CARROLL (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE James T Marsh M.D.

EXAMINER'S NAME (Type) JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 5/1/57

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF MAY 4, 1957

22c. NAME OF CEMETERY OR CREMATORY TRIDERS CEMETERY

22d. LOCATION (City, town, or county) WESTMINSTER (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE David C Bankard ADDRESS Westminster, Md.

24a. REC'D BY REGISTRAR DATE 5-4-57

24b. REGISTRAR'S SIGNATURE Hunter Willis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A1SME(S)
SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03943

3941 CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANCHESTER
c. LENGTH OF STAY IN 1b 70 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Res dence before admission)
a. STATE MD. b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANCHESTER,
d. STREET ADDRESS /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First GRACE Middle MAY Last WARD
4. DATE OF DEATH Month APRIL Day 15, Year 1957
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH OCTOBER 20 1886
9. AGE (In years last birthday) 70 yrs.
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME CHARLES HATFIELD
14. MOTHER'S MAIDEN NAME JULIA HARRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. [redacted]
17. INFORMANT JOHN V. WARD Address MANCHESTER, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b) Arteriosclerosis — 5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1952 to April 15, 1957 that I last saw the deceased alive on April 15, 1957, and that death occurred at 7:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE W H Foard M.D ADDRESS (Street, city or town, state) Manchester, Md. DATE SIGNED 4/17/57

PHYSICIAN'S NAME (Type) W. H. FOARD. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 4.18.1957
22c. NAME OF CEMETERY OR CREMATORY CEM. CHURCH of BRETHREN
22d. LOCATION (City, town, or county) SAMS CREEK (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE David C. Bankard ADDRESS Westminster, Md.
24a. REC'D BY REGISTRAR DATE 4-19-57
24b. REGISTRAR'S SIGNATURE Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be [illegible] for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4) 11M 9/55

A34

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03944

3942

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster — c. LENGTH OF STAY IN 1b: Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):	d. STREET ADDRESS: — e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Theodore Middle: W. Last: Welk

4. DATE OF DEATH: Month: April Day: 24 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 19, 1872

9. AGE (In years last birthday): 85 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Welk

14. MOTHER'S MAIDEN NAME: Savilla Starner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT / Address: Mr. Clarence E. Welk, Westminster, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — 24 hrs

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arterio Sclerotic Cardio Renal — 10 yrs

DUE TO (c) Disease c̄ myocardial degeneration

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 23, 1957, to April 24, 1957, that I last saw the deceased alive on April 23, 1957, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Glenn Speicher [illegible] M.D. — ADDRESS (Street, city or town, State): Westminster, Md. — DATE SIGNED: 4/25/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/26/57

22c. NAME OF CEMETERY OR CREMATORY: Pleasant Valley Cemetery

22d. LOCATION (City, town, or county) (State): Pleasant Valley, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Merwyn C. Fuss — Merwyn C. Fuss — ADDRESS: Taneytown, Maryland

24a. REC'D BY REGISTRAR DATE 4/26/57

24b. REGISTRAR'S SIGNATURE: Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3943

CERTIFICATE OF DEATH

Reg. Dist. No. 03945 76

1 PLACE OF DEATH
a COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER
c. LENGTH OF STAY IN 1b 6 MOS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RD 5

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER
d STREET ADDRESS RD 5
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First EDGAR Middle MCKAT Last WILHELM
4. DATE OF DEATH Month APRIL Day 12 Year 1957

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8 DATE OF BIRTH JULY 5 1873
9 AGE (In years last birthday) 83 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FAR
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME MATTHEW H. WILHELM
14. MOTHER'S MAIDEN NAME MARTELLEN FOREMAN

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16 SOCIAL SECURITY NO none
17. INFORMANT ELLEN DALEY Address RD 5 WESTMINSTER MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intestinal hemorrhage due to
DUE TO (b) cancer of bowel
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH about 6 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 15, 1957 to Apr 12, 1957 that I last saw the deceased alive on Apr 12, 1957, and that death occurred at 11:30 AM, from the causes and on the date stated above.
ACTUAL SIGNATURE Reese Wilkens, M.D.
ADDRESS (Street, city or town, state) 15 Kenwood Westminster
DATE SIGNED 4/13/57
PHYSICIAN'S NAME (Type) DR. REESE WILKENS

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF APRIL 16 1957
22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.
22d. LOCATION (City, town, or county) BALTO. (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE David C. Bankard ADDRESS Westminster Md
24a. REC'D BY REGISTRAR DATE 4-16-57
24b. REGISTRAR'S SIGNATURE Harriet Miller

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be [illegible] for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3944 CERTIFICATE OF DEATH

03946 15 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
c. LENGTH OF STAY IN 1b 9 1/2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jay-Dee Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminster
d. STREET ADDRESS 1 Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Laura Middle Evans Last Watson

4. DATE OF DEATH Month April Day 27 Year 19 57

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH May (?) 1855

9. AGE (In years last birthday) 101 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Vardin Evans

14. MOTHER'S MAIDEN NAME Emily Goodson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Address Self.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis
422.1
DUE TO (b) Senile Arteriosclerosis
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 —

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) (County) (State) — — —

21. I certify that I attended the deceased from Dec 28, 19 56, to April 27, 19 57, that I last saw the deceased alive on April 26, 19 57, and that death occurred at 11:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Joseph E Bush M.D. ADDRESS (Street, city or town, state) Hampstead Md DATE SIGNED 4/27/57

PHYSICIAN'S NAME (Type) Joseph E. Bush MD Hampstead Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 4/30/57

22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.

22d. LOCATION (City, town, or county) (State) Woodlawn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. J. Tickner & Sons - Balto 17, Md.

24a. REC'D BY REGISTRAR DATE 4-30-57

24b. REGISTRAR'S SIGNATURE M. F. McSherry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [redacted] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3945

CERTIFICATE OF DEATH

03947

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER
c. LENGTH OF STAY IN 1b 6 8YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RD 6

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MD. b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER X 2
d. STREET ADDRESS R.D. 6
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First VIRGIE Middle LENNIE Last ZEPP

4. DATE OF DEATH Month APRIL Day 20 Year 1957

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH NOV. 18, 1888

9. AGE (In years last birthday) 68 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME GEORGE G. STEM

14. MOTHER'S MAIDEN NAME IDA MAY POOLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address RD 6 MELVIN F. ZEPP WESTMINSTER, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 5 days

331X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1950, to Apr 20 - 1957, that I last saw the deceased alive on Apr 20 - 1957, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE W. C. Jarrett M.D. ADDRESS (Street, city or town, state) 103 E Main Westminster Md DATE SIGNED 4-22-57

PHYSICIAN'S NAME (Type) Wm Carl Jarrette MD, 103 E Main Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 4-23-1957

22c. NAME OF CEMETERY OR CREMATORY ZION CEMETERY

22d. LOCATION (City, town, or county) (State) RD 6, WESTMINSTER, MD.

23. FUNERAL DIRECTOR'S SIGNATURE David C. Bankard ADDRESS Westminster Md

24a. REC'D BY REGISTRAR DATE 4-24-57

24b. REGISTRAR'S SIGNATURE Hamit Miller

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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